ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Companion Document and Transaction Specifications for the HIPAA 834 Enrollment Transaction and 820 Capitation Transaction

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Revision History

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11/22/2002	1.0	Initial draft	AHCCCS Information Services Division
3/17/2003	1.1	Second draft with enhancements and Transaction Agreements	AHCCCS Information Services Division
7/31/2003	1.2	Draft for use in HIPAA Transaction and Code Set implementation	AHCCCS Information Services Division
9/9/2003	1.3	Draft with revised explanations of Acknowledgement Transactions and detail-level data modifications	AHCCCS Information Services Division
10/16/2003	1.4	Final Companion Document for 834 Enrollment Transaction and 820 Capitation Transaction	AHCCCS Information Services Division
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Table of Contents

1. Introduction **1**

1.1 Document Purpose 1
1.2 Contents of this Companion Document 4

2. 834 Enrollment and 820 Capitation Transactions **5**

2.1 Transaction Overview 5
2.2 834 Enrollment Transaction 8
2.3 820 Capitation Transaction 10

3. Technical Infrastructure and Procedures **12**

4. Transaction Standards **13**

4.1 General Information 13
4.2 Data Interchange Conventions 17
4.3 Acknowledgment Procedures 23
4.4 Rejected Transmissions and Transactions 28

5. Transaction Specifications **29**

5.1 About Transaction Specifications 29
5.2 834 Enrollment Transaction Specifications 30
5.3 820 Capitation Transaction Specifications 47

Appendix A – AHCCCS Action Code Translation Table **57**

1. Introduction

1.1 Document Purpose

Companion Documents

Companion Documents are available to external entities (health plans, program contractors, providers, third party processors, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with AHCCCS. The following Companion Documents are being produced:

- *834 Enrollment and 820 Capitation Transactions*
- 270 Eligibility Verification and 271 Eligibility Response Transactions
- 837 Claim Transactions
- 835 Electronic FFS Claims Remittance Advice Transaction
- 276 Claim Status Request and 277 Claim Status Response Transactions
- 837 and NCPDP Encounter Transactions
- U277 Unsolicited Encounter Status Transaction
- 278 Prior Authorization Transaction

This version of the 834/820 Companion Document is for AHCCCS acute and long term care health plans. The 834 Transaction for Arizona Children's Rehabilitative Services (CRS) and the 820 Transaction for CRS and Arizona Behavioral Health Services (BHS) are not covered.

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. They also address the security and privacy of health data.

The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange in health care. The intent of the law is that all electronic transactions, for which standards are specified, must be conducted according to the standards.

Covered entities are required to accept HIPAA Transactions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically. Both AHCCCS and its health plans are HIPAA covered entities.

Document Objective

This Companion Document provides information about the 834 Enrollment (Daily and Monthly Roster) and the 820 Capitation (Weekly Capitation Payment) Transactions that is specific to AHCCCS and AHCCCS trading partners. For these transactions, the document describes the ways in which health plans and program contractors receive information from AHCCCS.

Intended Users

The Companion Documents are intended for members of the technical staff of external entities who are responsible for electronic transactions and file exchanges.

Relationship to HIPAA Implementation Guides

Companion Documents are intended to supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This document describes the technical interface environment with AHCCCS, including connectivity requirements and protocols, and electronic interchange procedures. This document also provides specific information on the fields and values required for transactions sent to or received from AHCCCS.

Companion Documents are intended to supplement rather than replace the standard Implementation Guide for each transaction set. The information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between AHCCCS and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the provider contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize conflicts or errors; however, AHCCCS, the AHCCCS Information Services Division, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the AHCCCS Information Services Division immediately.

1.2 Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.
Transaction Overview	Section 2 provides an overview of the transactions included in this Companion Document including information on: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted AHCCCS files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with AHCCCS via electronic transactions.
Transaction Standards	Section 4 provides information relating to the transactions included in this Companion Document including: ▪ General HIPAA transaction standards ▪ Data interchange conventions applicable to the transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Agreements	Section 5 provides more specific information relating to the transactions sets included in this Companion Document including: ▪ A statement of the purpose of transaction agreements between AHCCCS and other covered entities. ▪ Detailed Transaction Specifications that show how AHCCCS populates the data elements in the 834 Enrollment and 820 Capitation Payment Transactions when AHCCCS uses transaction data elements in ways that are not fully described by information in a HIPAA Implementation Guide.

2. 834 Enrollment and 820 Capitation Transactions

2.1 Transaction Overview

Enrollment and Capitation Transactions

Historically, AHCCCS has provided member-level enrollment and capitation information on both Daily and Monthly Health Plan Membership Roster Files. HIPAA standards require enrollment and capitation information to be transmitted on different files composed of standard electronic transactions. To become HIPAA compliant, AHCCCS has split the information contained in the Daily and Monthly Roster Files by including enrollment-related information in the 834 Enrollment Transaction and capitation payment related information in the 820 Capitation Payment Transaction.

In addition, AHCCCS has moved information from other enrollment-related files, including the AHCCCS TPL File, and FYI File, into the 834 Enrollment Transaction. The 820 Capitation Transaction extracts payment data from tables in the AHCCCS Financial System that carry capitation payment information for health plan members. AHCCCS 820 data is equivalent to the financial data that formerly appeared on Daily, Monthly, and Mass Adjustment Rosters.

834 Enrollment Transaction

The 834 Enrollment Transaction is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy (AHCCCS) to a health care payer (an AHCCCS health plan). Enrollment in a particular AHCCCS health plan differs from more general eligibility for AHCCCS benefits. Under HIPAA, eligibility information is communicated by the 270/271 Eligibility Verification Transaction Set and detailed information on recipient enrollment in health plans or equivalent entities by the 834 Transaction.

Monthly 834 Transactions identify all active members of a health plan on a given date and are generated in association with monthly capitation pre-payments. Daily 834 Transactions provide data on both an individual's initial enrollment and on subsequent changes in enrollment. Through the AHCCCS Financial System, Daily 834 Updates generate partial month payments for new health plan enrollees and positive and negative adjustments for retroactive enrollments, enrollment terminations, and changes from one Rate Code to another.

The Daily 834 Transaction is unique among HIPAA Transactions in that entities external to AHCCCS (health plans) use data from it to update their systems. Monthly 834 Transactions are for purposes of audit and enrollment verification and are not intended for use in system updates.

820 Capitation Transaction

AHCCCS makes capitation payments and generates 820 Transactions on a weekly basis. Monthly capitation pre-payments, payments and adjustments from Daily 834s, and payments resulting from ad hoc mass adjustments are all processed in weekly payment cycles. Amounts deducted from or added to capitation payments due to such things as health plan sanctions or negotiated settlements are also reported on 820 transactions but on a summary rather than an individual member level.

AHCCCS issues financial vouchers from multiple funding sources (for example, acute and long term care) when it makes capitation payments. Each detailed payment documented on the 820 Transaction has a Voucher Number from the Financial System associated with it. The same Voucher Number is associated with member enrollment lines on the 834 Enrollment Transaction. This association makes it possible for receivers of both 820 and 834 Transactions to audit payments at the member level.

Processes Replaced or Impacted

The primary processes replaced by the 834 Enrollment and 820 Capitation Transactions are the Daily and Monthly Roster File interfaces. Data from Rosters is augmented by data from the TPL Interface File and split between the transactions.

834 Enrollment Transaction

Replaced Files

- Daily and Monthly Roster Files (enrollment components)
- FYI File (other program eligibility)

Impacted File

- Third Party Liability (TPL) File

820 Capitation Transaction

Replaced Files

- Daily and Monthly Roster Files (Capitation Payment components)
- Capitation Payment Remittance Advice

Impacted File

- Mass Adjustment File

Payment amounts, check numbers, and payment dates on monthly 820 Transactions must match corresponding information on the electronic payments or checks that AHCCCS sends to health plans. Mass Adjustments are also handled by the 820 Capitation Transaction. AHCCCS continues to send TPL and Mass Adjustment Files to health plans because the functions of these files are only partially met by HIPAA Transactions.

Other Related Information

AHCCCS continues to produce several enrollment-related files in the Agency's proprietary format.

2.2 834 Enrollment Transaction

Purpose

The 834 Enrollment Transaction transmits enrollment information from the sponsor of the insurance coverage (AHCCCS) to a health care payer (an AHCCCS Health Plan) on a daily and monthly basis. The daily version of this transaction provides data on initial enrollments, enrollment terminations, and subsequent changes to member-level enrollment data. The monthly version provides a listing of active members that is the basis for the health plan's monthly capitation pre-payment.

The Daily 834 Enrollment Transaction is used to identify:

- New members for whom the health plan is responsible
- Terminated or deceased members for whom the health plan is no longer responsible
- Demographic changes for each member such as changes in name, address or date of birth
- Other changes for each member such as changes in Rate Code or TPL coverage

The Monthly 834 Enrollment Transaction is used to:

- Reconcile health plan and AHCCCS member files
- Audit updates to health plan data applied from Daily 834 Transactions during the previous month

Member lines on both Daily and Monthly 834 Transactions carry Voucher Numbers when they result in capitation payments or adjustments. Corresponding Voucher Numbers also appear on payment lines in the 820 Capitation Payment Transaction and can be used to link enrollments to member level capitation payments.

Standard Implementation Guide

The standard Implementation Guide for the 834 Enrollment Transaction is the ANSI Accredited Standards Committee (ASC) X12 Transaction Set Implementation Guide for Benefit Enrollment and Maintenance and all approved Addenda. Versions of the 834 Enrollment Transaction Implementation Guide and Addenda adopted by AHCCCS and other covered entities and used in preparation of this document are:

- ASC X12N 834 (004010X095)
- ASC X12N 834 (004010X095A1) (Addenda)

Related Transactions

As used by AHCCCS, Transaction Specifications for the 820 Capitation Transaction are closely related to Transaction Specifications for the 834 Transaction. All member level capitation payments and adjustments correspond to monthly prepayments, new enrollments, enrollment changes, or mass adjustments due to retroactive rate changes for individual health plan members.

Transmission Schedules

Daily 834 Transactions

An 834 Daily Enrollment Transaction that shows new members, terminated or deceased members and demographic or other changes to current members is produced every day. This file is generally available to the health plan on the AHCCCS Communication Server based on the following schedule:

Available at: 10:00 PM
Available for: 7 days from the date of processing

If no member data is present for a receiving health plan on a Daily 834, AHCCCS informs the health plan by writing a non-HIPAA transaction similar to the pre-HIPAA "no data" record to the FTP Server.

Monthly 834 Transactions

The 834 Monthly Enrollment Transaction File contains a roster of all currently active members. It is produced monthly and is generally available to each health plan on the AHCCCS Communication Server based on the following schedule**.**

Available at: 7:00 AM on the morning of the third day before the end of the month. For example, in a 31-day month, the 834 Monthly Enrollment transaction will be available on the twenty-ninth day of the month.
Available for: 30 days from the date of processing

2.3 820 Capitation Transaction

Purpose

The 820 Capitation Transaction is a weekly file that provides each AHCCCS health plan with an electronic remittance advice for its capitation payments. AHCCCS makes all capitation payments on a weekly basis with an electronic payment or check to each capitated health plan. The weekly 820 can accumulate and report capitation payments generated during the prior week by Daily Rosters, Monthly Rosters, and ad hoc Mass Adjustment Files. Financial sanctions and other payments to and recoupments from health plans that are not member specific can also be carried on the 820. Partial capitation payments can be accommodated on the 820 as organization level negative payments.

The AHCCCS Division of Budget and Finance (DBF) controls payment data on the 820 through the Oracle Financial System. Finance specifies the Oracle Invoice Numbers (derived from Voucher Numbers generated in PMMIS) to be included in each weekly payment. Although more than one Invoice Number can appear on a Roster, Finance specifies Invoice Numbers in a way that includes full Daily Roster data in each payment. Rosters are not normally split between payments.

Finance makes an exception to the weekly payment inclusiveness rule for Daily or Mass Adjustment Rosters that result in negative payments to a health plan. Because payments cannot be made for negative amounts, these rosters are saved for payment until the next Monthly Pre-Payment Cycle when the payment total is certain to be higher than any negative adjustment.

The 820 Transaction is used to:

- Show monthly capitation pre-payments for each health plan member
- Show pro-rated payments for each health plan member who joined during the previous month
- Show positive or negative adjustments that reflect changes to previous capitation payments
- Show positive or negative Rate Code adjustments based on retroactive capitation rate changes by AHCCCS (mass adjustments)
- Show AHCCCS payments and recoveries that are not member specific, including financial sanctions imposed by AHCCCS due to late encounter submission

For AHCCCS, the concept of retroactive capitation adjustments is different from the adjustments to current payments supported by the 820 Transaction. For this reason, payments and recoupments reported on the 820 are always considered original payments rather than 820 adjustments.

Standard Implementation Guide

The standard Implementation Guide for the 820 Transaction is the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Transaction Set Implementation Guide for the Health Care Claim Status Request and Response Transactions and all approved Addenda. Versions of the 820 Implementation Guide and Addenda adopted by AHCCCS and other covered entities and used in preparation of this document are:

- ASC X12N 820 (004010X061)
- ASC X12N 820 (004010X061A1) (Addenda)

Related Transactions

Transaction Specifications for the 820 Capitation Transaction are closely related to Transaction Specifications for the 834 Transaction. All capitation payments and adjustments (with the exception of health plan payments and recoupments that are not member specific) correspond to monthly prepayments, new enrollments, enrollment changes, or Rate Code rate change adjustments (mass adjustments) for individual health plan members.

Transmission Schedules

The 820 Capitation Transaction File is produced weekly and is generally available to each health plan on the AHCCCS Communication Server based on the following schedule:

Available at:	7:00 AM on Monday or Tuesday morning of the day that weekly capitation payments are issued.
Available for:	30 days from the date of processing

3. Technical Infrastructure and Procedures

AHCCCS Data Center Communications Requirements

Trading partners receive 834 and 820 Transactions from AHCCCS by connecting to the AHCCCS Central Site Network. They go from the Internet through a Virtual Private Network (VPN) tunnel to the AHCCCS File Transfer Protocol (FTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires FTP access.

Trading partners can contact the AHCCCS Customer Support Center (see below for the phone number) for more information on establishing connections through the FTP Server.

Technical Assistance and Help

The AHCCCS Information Services Division (ISD) Customer Support Center provides technical assistance related to questions about electronic claims submission or data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** (602) 417-4451
- **Hours:** 8:00 AM – 5:00 PM Arizona Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (VPN setup, FTP procedures, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Customer Support Center

4. Transaction Standards

4.1 General Information

HIPAA Requirements

HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. Currently, both the 834 Enrollment and the 820 Capitation Transactions have one draft Addendum each. These Addenda have been adopted as final and are incorporated into AHCCCS requirements.

An overview of requirements specific to each transaction can be found in the 834 and 820 Implementation Guides. Implementation Guides contain information related to:

- Format and content of interchanges and functional groups
- Format and content of the header, detailer and trailer segments specific to the transaction
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

Size of Transmissions/ Batches

Transmission sizes are limited based on two factors:

- Number of Segments/Records allowed by HIPAA standards
- AHCCCS file transfer limitations

HIPAA standards for the maximum file size of each transaction set are specified in the appropriate Implementation Guide or its authorized Addenda. The 834 Implementation Guide recommends a limit of 10,000 INS Member Level Detail Segments in the 2000 Member Level Detail Loop.

AHCCCS has no size limitations for postings to its FTP Server.

834 Transactions

Due to the need to create multiple 2000 Loops and INS Segments by member on Daily Rosters when an update has multiple PMMIS Action Codes, fewer than 10,000 members can normally be accommodated on an 834 Transaction.

The AHCCCS translator maintains segment counts and will automatically limit 834 Transactions (data between ST and SE Segments) to 10,000 INS Segments. Because members frequently have multiple INS Segments, the 10,000 Segment cut-off is sometimes mid-member. Health plans with many thousands of members can expect to sometimes receive multiple 834 Transactions within a functional group, especially for Monthly 834s.

820 Transactions

For 820 Capitation Transactions, there is no Implementation Guide limit to the number of individual members on the same transaction. The number of 2000B Individual Remittance Loops on the Monthly 820 Transaction reflects the number of member-level capitation payments and adjustments posted for payment and in need of processing.

For large AHCCCS health plans, Monthly 820 Transactions will sometimes have hundreds of thousands of 2000B Individual Remittance Loops. This is because of the Implementation Guide's requirement that the Total Payment Amount on the 820 Transaction match the amount of a check or electronic fund transfer.

Other Standards

820 Capitation Transaction

Balancing Financial Data

There are two types of balancing procedures that both AHCCCS and its health plans can use to ensure the accuracy of the data in the 820 Capitation Transaction. They are:

- Balancing the total amount of the payment to the capitation receiver (820 Element BPR02) to the sum of all individual capitation payments (Element RMR04). The BPR02 element can only occur once in the entire 820 Capitation Transaction while the member-level RMR04 can occur any number of times.

  When payments or recoupments that are not specific to plan members (e.g., settlements and sanctions) are present, they appear in the 820's 2000A Organization Summary Loop. RMR04 Payment Amounts within the organization level 2000A Loop as well as the member level Payment Amounts in the 2000B Loop are included in the transaction level BPR02 total.

- Balancing between the total amount of the payment to the capitation receiver (element BPR02) and the amount of the weekly capitation payment to the health plan (a payment issued by the AHCCCS Financial System).

  This critical balancing procedure is performed automatically. The AHCCCS translator will raise an electronic red flag if the 820 total and the check amount fail to balance. Should this happen, the AHCCCS Information Services Division (ISD) will correct the problem before placing 820 Transactions on its FTP Server for use by health plans.

Remittance Tracking

The Trace Number (element TRN02) and the Payer Identification Number (element TRN03) in the 820 Transaction's Reassociation Key (TRN) Segment should be used to reassociate the remittance advice data in the 820 Capitation Transaction with the payment sent separately by the AHCCCS Fiscal Agent. For AHCCCS, TRN02 is the Payment Number of the electronic transfer or check written for capitation payment by the AHCCCS Financial System.

Sequence of 2000B Individual Remittance Loops

On the 820 Transactions that it creates for individual member payments, AHCCCS primarily populates the Individual rather than the Organization Summary version of the 2000 Loop (Loop 2000B rather than 2000A). Each occurrence of 2000B is equivalent to a Daily, Monthly, or Mass Adjustment Roster Record for a health plan member. Members are in sequence by AHCCCS ID and the From Date of the period covered by the payment. Sometimes, a member appears on more than one 2000B Loop because of multiple payments and adjustments.

The content of Daily, Monthly, or ad hoc Mass Adjustment groupings is the same as the content of the succession of Roster Files that AHCCCS health plans received in the pre-HIPAA environment. The major difference is that health plans now get capitation payment data once a week rather than in smaller, scattered pieces.

4.2 Data Interchange Conventions

Overview of Data Interchange

When transmitting 834 and 820 Transactions to health plans, AHCCCS follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 834 and 820 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B1 of Implementation Guides.

Transaction Agreements that specify how individual data elements are populated by AHCCCS on ISA/IEA and GS/GE envelopes are shown in the table beginning later in this section. This document assumes that security considerations involving user identifiers, passwords, and encryption procedures are handled by the AHCCCS FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

AHCCCS transmits 834 and 820 Transactions within single ISA/IEA and GS/GE envelopes. 834 Enrollment Transactions, with their limit of 10,000 members per transaction, sometimes have multiple transactions (as defined by ST and SE Segments) within the same GS/GE envelope. 820 Transactions, because they must always correspond to payments, can have any number of payment lines within a transaction and only one transaction per GS/GE envelope.

Outer Envelope Specifications Table

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the

industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values
The valid values from the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Characters	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 characters		Leave field blank – not used by AHCCCS.
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 characters	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters		Leave field blank – not used by AHCCCS.
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 characters		“AHCCCS” followed by the nine-digit AHCCCS Federal Tax ID Number (866004791)
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 characters		AHCCCS Health Plan ID
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 characters	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		The Interchange Control Number. ISA13 must be identical to the control number in associated Interchange Trailer field IEA02.
NA	ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	1	Interchange Acknowledgement Requested AHCCCS does not require TA1 Interchange Acknowledgement Segments from its trading partners. If trading partners send them, however, the AHCCCS translator will receive them and notify AHCCCS staff of their receipt.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P or T	Production Data or Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character	|	A “pipe” (the symbol above the backslash on most keyboards) is the value used by AHCCCS for component separation. Segment and element level delimiters are defined by usage in the ISA Segment and do not require separate ISA elements to identify them. Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by AHCCCS on outgoing transactions: Segment Delimiter - “~’ (tilde – hexadecimal value X”7E”) Element Delimiter - “{“ (left rounded bracket – hexadecimal value X”7B”)

ISA/IEA INTERCHANGE CONTROL ENVELOPE TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
						Composite Component Delimiter (ISA16) - "|" (pipe – hexadecimal value X"7C") These values are used because they are not likely to occur within transaction data.
IEA INTERCHANGE TRAILER						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 characters		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE TRANSACTION SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	BE RA	Benefit Enrollment and Maintenance (834) Payment Order/Remittance Advice (820)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		AHCCCS repeats the Sender Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		AHCCCS repeats the Receiver Identifier used in the ISA Segment.	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMMSS format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		834 Transaction: 004010X095A1 820 Transaction: 004010X061A1 AHCCCS uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the final Addenda.	HIPAA Code Set
GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

4.3 Acknowledgment Procedures

Overview of Acknowledgment Processes

Although AHCCCS does not require receivers of 834 and/or 820 Transactions to return electronic acknowledgements, it accepts and processes the following ASC X12 Transactions from 834 and 820 receivers:

- TA1 Interchange Acknowledgement Transactions
- 997 Functional Acknowledgement Transactions
- 824 Implementation Guide Reporting Transactions

Trading partners can use the TA1 Transaction to acknowledge receipt of transmissions or "interchanges" of X12 Transactions and to tell AHCCCS of problems in the ISA/IEA Interchange Envelope. A 997 can be sent as an acknowledgement for each GS/GE Envelope or Functional Group of one or more transactions within the interchange or to report on some types of syntactical errors. The 824, with its substantial error handling capabilities, reports syntactical errors within 834 or 820 Transactions received from AHCCCS.

The Mercator Translator used by AHCCCS accepts and reports on all three transactions. It automatically pages AHCCCS technical staff when it receives an electronic acknowledgement. AHCCCS staff members go online for additional information prior to correcting and re-transmitting any interchanges with invalid data.

Extensive syntactical problems are not anticipated because AHCCCS applies translator edits to outgoing as well as incoming transactions and corrects any problems revealed by the translator prior to transmission. Discrepancies are possible, however, due to variations in sender and receiver edits.

AHCCCS Interchange Flow Diagrams for 834 and 820 Transactions appear later in this section. The flows are similar. Both transactions are built from PMMIS and, for the 820, Financial System data. They are both processed by the AHCCCS translator and posted to the AHCCCS FTP Server, to be downloaded by receiving health plans.

TA1 Interchange Acknowledgement Transaction

The TA1 is really a segment of fixed-length fields rather than a full-blown X12 Transaction. In the X12 environment, the TA1 can be used to either acknowledge receipt of a valid transmission or file by a trading partner and/or to tell the trading partner of interchange errors. The TA1 does not cover data within functional envelopes or X12 transactions.

A trading partner that sends a TA1 to report interchange errors to AHCCCS should not attempt to process the transaction data within the 834 or 820 transmission for which the TA1with error codes is sent.

Detailed information on TA1 data elements appears in Appendix B of all HIPAA Implementation Guides.

997 Functional Acknowledgement Transaction

Like the TA1, the 997 Functional Acknowledgment Transaction is designed to both acknowledge receipt of a valid functional group of X12 Transactions or to report on some types of syntactical errors. Functional groups consist of one or more X12 Transactions as defined by GS/GE Functional Envelopes within ISA/IAE Interchanges. AHCCCS is prepared to receive 997 Transactions as acknowledgements of valid functional groups of 834 or 820 Transactions and as reports of transaction errors.

For the 834 and 820, AHCCCS plans to always send 834 and 820 Transactions within a single functional group per transmission. This practice makes the "domain" of the 997 the same as that of the TA1.

Details on the format and syntax of the 997 Transaction can be found in Appendix B of each Transaction Set's Standard Implementation Guide.

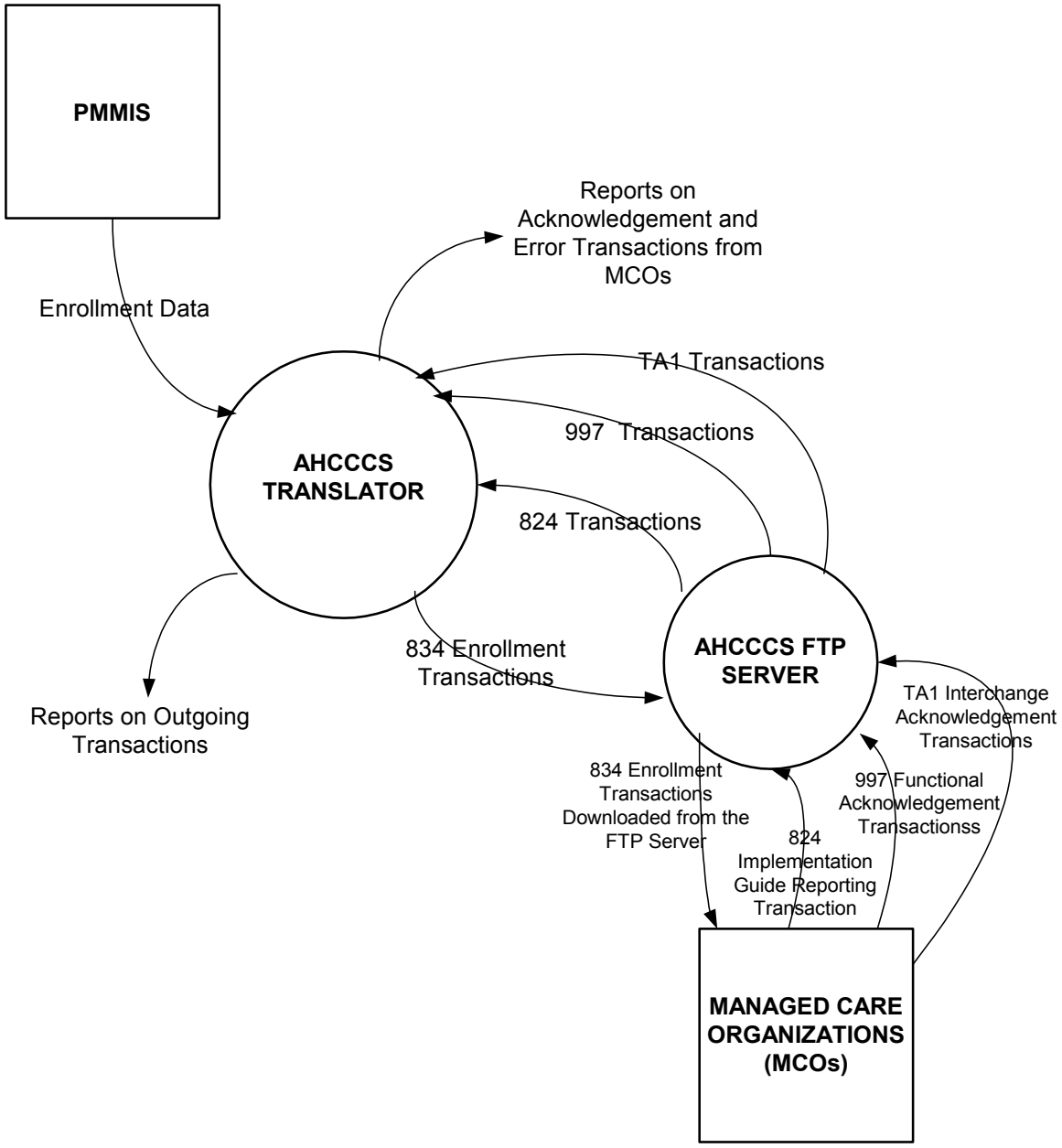
824 Implementation Guide Reporting Transaction

The 824 Transaction reports on deviations from Implementation Guide standards. These deviations can involve format conventions at transaction, segment, and data element levels as well as presence of required segments and elements and validity of element values defined in the transaction's Implementation Guide. The 824 can use both standard HIPAA compliant code sets and proprietary code sets to report errors.

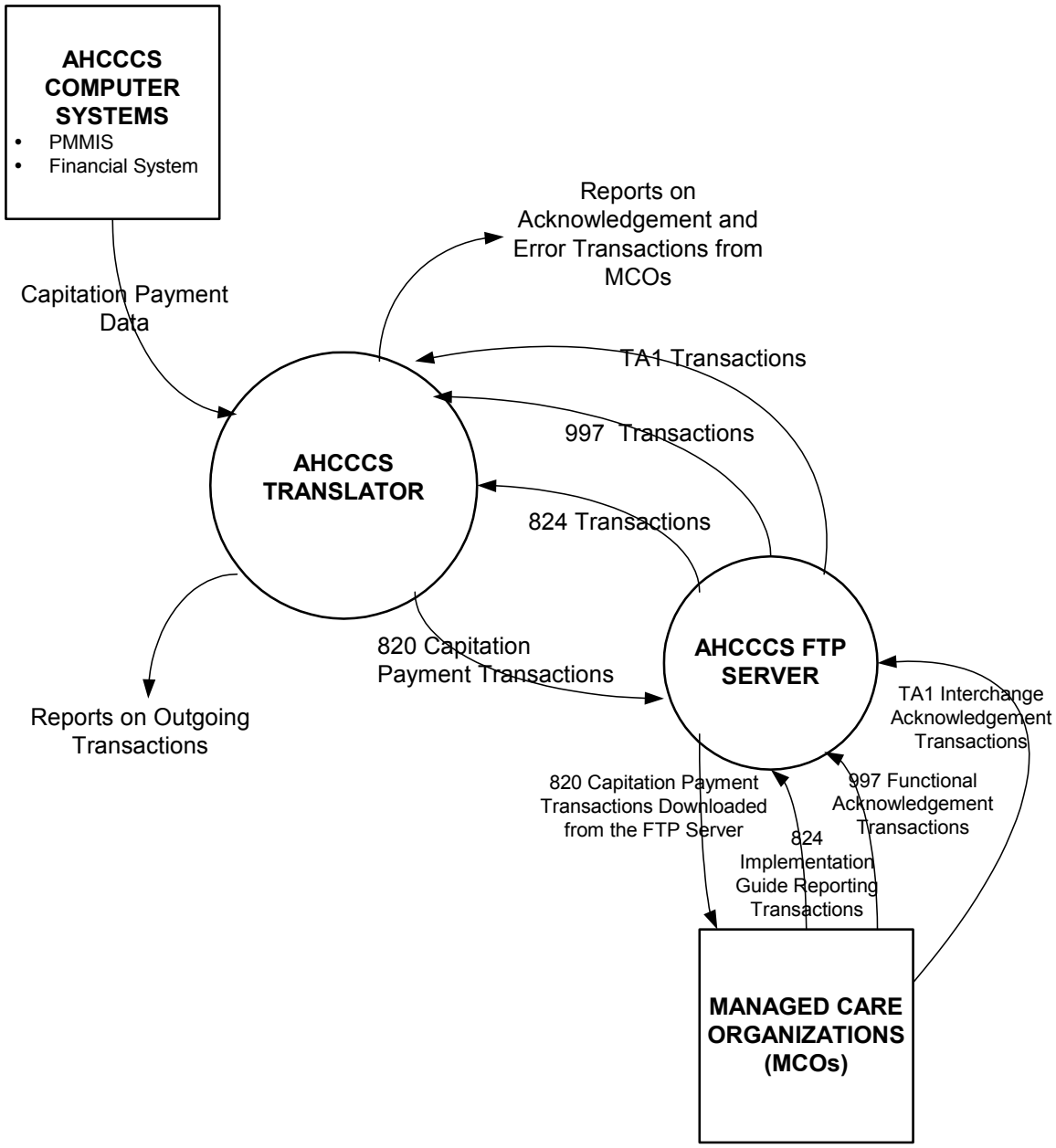
AHCCCS anticipates 824 Transactions from receivers of 834 and 820 Transactions when receiver software detects syntactical errors within the 824's domain. As with the TA1, trading partners that return 824 error Transactions to AHCCCS should not make use of any data within the affected interchange. AHCCCS will correct and retransmit all data within the interchange.

A final Implementation Guide for the 824 Transaction has been published and is available at cost from the Washington Publishing Company (http://www.wpc-edi.com).

AHCCCS Interchange Flow for 834 Transactions



AHCCCS Interchange Flow for 820 Transactions



4.4 Rejected Transmissions and Transactions

Overview of Rejection Process

AHCCCS expects that its 834 and 820 transmissions will either be accepted and processed by trading partners or, if they have syntactical problems, rejected without further processing. This means that a receiver that rejects any part of a transmission must reject the entire transmission. Data on rejected 834 or 820 transmissions should not be used to update health plan databases.

All three of the transactions discussed in the previous section can be used to reject 834 and 820 Transactions at interchange, functional group, and transaction levels.

AHCCCS transmits 834 Transactions within single functional groups, even when multiple transactions (ST through SE Segments) are required. There is no limit to the number of members for whom capitation payment data can be carried on the 820 and no need to have more than one 820 Transaction within a functional group.

5. Transaction Specifications

5.1 About Transaction Specifications

Purpose

Transaction Specifications describe the codes that AHCCCS allows between trading partners and specify the type and format of the information that will be included in data elements. In some cases these values are subsets of the data element values listed in Implementation Guides. In others, they are specific to AHCCCS requirements.

For example, in a transaction's Subscriber Number Loop (Loop 2000), element REF02 is defined as an alphanumeric reference identification field that is between one and thirty characters long. In the 834 Enrollment Transaction Agreement, REF02 has been defined as the member's AHCCCS ID.

Both 834 and 820 Transactions contain data elements into which multiple AHCCCS fields are "strung". AHCCCS has taken care that its stringing of AHCCCS data elements does not violate the meanings or functions described in a transaction's HIPAA Implementation Guide. Within strings, fixed length AHCCCS fields, if necessary, are padded with trailing spaces or, for numeric fields, leading zeros. Any absent AHCCCS fields prior to the final field in the string are replaced with spaces or zeros.

Relationship to HIPAA Implementation Guides

Transaction agreements are intended to supplement the data in the Implementation Guides for each HIPAA Transaction with specific information pertaining to the trading partners using the transaction.

The information in the Transaction Agreements is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2 834 Enrollment Transaction Specifications

Overview

The 834 Enrollment Transaction contains information on new member enrollments, enrollment terminations, and changes to information on currently enrolled members. The purpose of the Transaction Specifications in this document is to identify the data elements used in the 834 Enrollment Transaction so that health plans are able to understand and process the data they receive from AHCCCS.

Transaction Specifications Table

834 Enrollment Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
The valid values from the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	834	Benefit Enrollment and Maintenance
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set		Must match the number in SE02 at the end of the transaction.
N/A	BGN	BGN01	Transaction Set Purpose Code	Code identifying purpose of transaction set	00	Original Transmission AHCCCS normally populates this element with “00”. Values on resubmissions will be coordinated with trading partners.
N/A	BGN	BGN02	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set		AHCCCS assigns a unique Transaction Number to each 820 Transaction.
N/A	BGN	BGN03	Transaction Set Creation Date	Identifies the date the submitter created the transaction		CCYYMMDD format
N/A	BGN	BGN04	Transaction Set Creation Time	Time file is created for transmission		Time expressed in HHMMSSDD format. DD is a hundredth of a second. This is the time at which the 834 Transaction is created.
N/A	BGN	BGN05	Time Zone Code	Code identifying the time zone	MS	Mountain Standard Time
N/A	BGN	BGN06	Transaction Set Identifier Code	Code uniquely identifying a transaction set		BGN02 value from the original transaction when BGN01 is not “00”.
N/A	BGN	BGN08	Action Code	Code indicating type of action	2 4	Change Update. BGN08 “2” transactions contain Adds, Terminations and Changes (equivalent to the Daily Roster). BGN08 “4” transactions contain snapshots of all active health plan members (equivalent to the Monthly Roster). AHCCCS generates both kinds of transactions.
N/A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	38	Master Policy Number
N/A	REF	REF02	Master Policy Number	The identification of the master policy providing coverage for the entities identified in the transaction		Six-digit AHCCCS Health Plan ID
1000A	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	P5	Plan Sponsor

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000A	N1	N102	Plan Sponsor Name	The name of the entity providing coverage to the subscriber	AHCCCS	Payer Name
1000A	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Tax ID Number
1000A	N1	N104	Sponsor Identifier	Identification of the party paying for the coverage	866004791	AHCCCS Federal Tax ID Number
1000B	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	IN	Insurer
1000B	N1	N102	Insurer Name	Name of the insurer providing coverage		Health Plan Name
1000B	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Tax ID Number
1000B	N1	N104	Insurer Identification Code	Code identifying the insurer providing coverage		Health Plan Federal Tax ID
2000	INS	INS01	Insured Indicator	Indicates whether the insured is the subscriber or a dependent	Y	Yes. By definition, all AHCCCS members are subscribers.
2000	INS	INS02	Individual Relationship Code	Code indicating the relationship between two individuals or entities	18	Self
2000	INS	INS03	Maintenance Type Code	Code identifying a specific type of item maintenance		The Maintenance Type Code in the 2000 Loop is at the member level. The element reappears at the coverage level in the 2300 Loop. <u>Used when BGN08 = 2 (Daily Roster)</u> 001 Change. Action Type “C” on the pre-HIPAA Daily Roster 021 Addition. Action Type “A” on the pre-HIPAA Daily Roster 024 Termination. Action Type “D” on the pre-HIPAA Daily Roster <u>Used when BGN08 = 4 (Monthly Roster)</u> 030 Audit/Compare. No equivalent AHCCCS Action Type
2000	INS	INS04	Maintenance Reason Code	Code identifying reason for the maintenance change		This critical data element is functionally equivalent to Action Code on pre-HIPAA Daily Rosters. See Appendix A, AHCCCS Action Code Translation Table, for information on how specific Action Codes are

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
						handled. Maintenance Reason Code values and meanings are quite different. Only a single occurrence of Maintenance Reason Code is allowed per 2000 Loop (rather than the up to eight Action Code occurrences per update record that appeared on pre-HIPAA Daily Roster Records). Because of the single occurrence limitation, each of the valid AHCCCS Action Code values for member changes (with three exceptions) generates a separate 2000 Loop and INS Segment. Exceptions are: • The three AHCCCS Action Code values that relate to name and demographic changes (“NC”, “DB”, and “SX”) Any or all of these Action Codes are translated and accommodated on a single 2000 Loop. For the 834 Transaction, demographic changes are defined as changes to a member’s Date of Birth and/or Gender. • The AHCCCS Action Codes that have a financial impact but no impact on member data (“HK” and “SB”) Daily Roster updates with these Action Code values will not appear on the 834 but will appear on the 820 Capitation Transaction. • Action Codes that trigger changes that affect lower-level loops but not the 2000 Loop of the 834 Transaction (“MC”, “PG”, and “TM”) For code descriptions and a complete cross reference between AHCCCS Daily Roster Action Codes and Maintenance Reason Codes on the 834 Transaction, refer to Appendix A, AHCCCS Action Code Translation Table**.**
2000	INS	INS05	Benefit Status Code	The type of coverage under which benefits are paid	A	Active

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000	INS	INS06	Medicare Plan Code	Code identifying the Medicare Plan	 A B C E	Equivalent to the following Medicare Coverage Codes from pre-HIPAA Daily and Monthly Rosters: <u>Pre-HIPAA Values</u> Medicare Coverage A = Y and Medicare Coverage B = N Medicare Coverage A = N and Medicare Coverage B = Y Medicare Coverage A = Y and Medicare Coverage B = Y Medicare Coverage A = N and Medicare Coverage B = N
2000	INS	INS08	Employment Status Code	A code used to define the employment status of the individual covered by this insurance payer	FT	Full Time. This element is required by the 834 Implementation Guide but has no meaning for AHCCCS.
2000	INS	INS11	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in CCYYMMDD format Only populated if Date of Death is present for the member on the PMMIS database. Date of Death is only populated on Daily Roster Files – there are no monthly capitation pre-payments for deceased members.
2000	INS	INS12	Insured Individual Death Date	Date of death for subscriber or dependent		Date of Death. This field is only populated on Daily Roster Files.
2000	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	0F	Subscriber Number
2000	REF	REF02	Subscriber Identifier	Insured's or subscriber's unique identification number assigned by a payer		AHCCCS Recipient ID

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification		HIPAA allows up to five additional IDs for a member. AHCCCS uses the Subscriber Supplemental Identifier REF Segment in five different ways as indicated by selected Implementation Guide values for REF01.
					17	Client Reporting Category (Used for Payment Voucher Number by AHCCCS)
					3H	Case Number
					F6	Medicare Health Insurance Claim Number (HIC)
					ZZ	Mutually Defined (Used by AHCCCS for Primary ID Numbers on enrollment terminations due to ID changes)
2000	REF	REF02	Subscriber Supplemental Identifier	Identifies another or additional distinguishing code number associated with the subscriber		Member Identifier based on the code supplied in REF01
2000	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	356	Eligibility Begin Date = The member's Enrollment Begin Date with the receiving health plan
					357	Eligibility End Date = The member's Enrollment End Date with the receiving health plan
					303	Maintenance Effective Date = The process date of the 834 Change Transaction Use of dates that correspond to these values is discussed with Element DTP03 below.
2000	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in CCYYMMDD format.
2000	DTP	DTP03	Status Information Effective Date	The date that the status information provided is effective		For Daily Adds (new enrollments) and Monthly 834s, this element is populated with the Enrollment From Date (Qualifier "356"). For Terminations (disenrollments), this element is populated with the Enrollment End Date (Qualifier "357"). In retroactive "block in/block out" situations, AHCCCS generates separate DTP Segments for Enrollment From and Enrollment End Dates. For Changes, this element is populated with the Process Date of the Daily Update (Qualifier "303").

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100A	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	74 IL	Corrected Insured. Used if a member's name (or name and/or Date of Birth and/or Gender) is being changed. Insured/Subscriber. Used when enrolling a new member, updating member data with no change in identifying information, or updating only Date or Birth and/or Gender but not Name.
2100A	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100A	NM1	NM103	Subscriber Last Name	The surname of the insured individual or subscriber to the coverage		Member's last name, including suffix if present
2100A	NM1	NM104	Subscriber First Name	The first name of the insured individual or subscriber to the coverage		Member's first name
2100A	NM1	NM105	Subscriber Middle Name	The middle name of the subscriber to the indicated coverage or policy		Member's middle name or initial if present
2100A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	34	Social Security Number Only used when the member's SSN has been verified.
2100A	NM1	NM109	Subscriber Identifier	Insured's or subscriber's unique identification number assigned by a payer		Social Security Number. Used if NM108 above is 34.
2100A	PER	PER01	Contact Function Code	Code identifying the major duty or responsibility of the person or group named	IP	Insured Person Only populated when a home telephone number is available for the member.
2100A	PER	PER03	Communication Number Qualifier	Code identifying the type of communication number	HP	Home Phone Number Only populated when a home telephone number is available for the member.
2100A	PER	PER04	Communication Number	Complete communications number including country or area code when applicable		Home Telephone Number Only populated when PER01 above is "IP" and PER03 above is "HP".

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100A	PER	PER05	Communication Number Qualifier	Code identifying the type of communication number	TE	Telephone Only populated when an emergency telephone number is available for the member.
2100A	PER	PER06	Communication Number	Complete communications number including country or area code when applicable		Emergency Telephone Number. Only populated if PER05 above is TE.
2100A	N3	N301	Subscriber Address Line	Address line of the current mailing address of the insured individual or subscriber to the coverage		First line of member's residence street address.
2100A	N3	N302	Subscriber Address Line	Address line of the current mailing address of the insured individual or subscriber to the coverage		Second line of member's residence street address, if present
2100A	N4	N401	Subscriber City Name	The City Name of the insured individual or subscriber to the coverage		Member's residence city
2100A	N4	N402	Subscriber State Code	The State Code of the insured individual or subscriber to the coverage		Member's residence State Code
2100A	N4	N403	Subscriber Postal Zone or ZIP Code	The ZIP Code of the insured individual or subscriber to the coverage		Member's residence Zip Code (9 digit when available)
2100A	N4	N405	Location Qualifier	Code identifying type of location	CY	County/Parish
2100A	N4	N406	Location Identification Code	Code which identifies a specific location		AHCCCS County Code
2100A	DMG	DMG01	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in CCYYMMDD format.
2100A	DMG	DMG02	Member Birth Date	The date of birth of the member to the indicated coverage or policy		Date of Birth
2100A	DMG	DMG03	Gender Code	A code indicating the gender of the patient or insured	F M	Female Male

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100A	DMG	DMG04	Marital Status Code	Code defining the marital status of a person		AHCCCS Marital Status values can be used because they are identical to HIPAA values. Marital Status Codes appear on Monthly 834s and on Daily Adds. A change in Marital Status Code does not generate a Daily Roster Change and Marital Status Codes do not appear on Daily 834 Changes. <u>Descriptions of Values used by both AHCCCS and the 834 Transaction</u> B Registered Domestic Partner D Divorced I Single M Married R Unreported S Separated U Unmarried (divorced, single or widowed) - use if no prior marital W status X Widowed Legally Separated
2100A	DMG	DMG05	Race or Ethnicity Code	Code indicating the racial or ethnic background of a person		AHCCCS and HIPAA Race/Ethnicity Codes have different values but corresponding meanings. They are equivalent to the Ethnicity Code on pre-HIPAA Daily and Monthly Rosters. <u>AHCCCS Values</u> 7 UN (Unknown/Unspecified) A AS (Asian/Pacific Islander) B BL (Black) C CW (Caucasian) H HS (Hispanic) G NA (Native American)
2100A	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	C1	Co-Payment Amount
2100A	AMT	AMT02	Monetary Amount	Contract Amount		The co-pay for generic prescriptions. The 834 does not allow for AHCCCS to specifically indicate mandatory versus optional co-pays. In order to communicate mandatory versus optional co-pays, if the first occurrence of the C1 is 0 (no dollars), then the member's co-pay is optional. If the first occurrence is greater than 0, then the member's co-pay is mandatory.

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100A	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	C1	Co-pay amount
2100A	AMT	AMT02	Monetary Amount	Contract amount		Co-pay for Brand Name Rx.
2100A	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	C1	Co-pay amount
2100A	AMT	AMT02	Monetary Amount	Contract amount		Co-pay for Non-Emergency use of ER
2100A	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	C1	Co-pay amount
2100A	AMT	AMT02	Monetary Amount	Contract amount		Co-pay for Office visits
2100A	**LUI**	**LUI01**	**Identification Code Qualifier**	**Code designating the system/method of code structure used for Identification Code**	LE	ISO 639 Language Codes AHCCCS uses three-character ISO 639-2 Codes. Some, but not all, of the ISO 639-2 Codes used by AHCCCS have the same values as NISO Z39.53 Language Codes. AHCCCS uses the LUI Segment for the primary language spoken in the member's household.
2100A	LUI	LUI02	Language Code	Code indicating the language spoken by an individual		Language Codes appear on Monthly 834s and on Daily Adds. A change in Language Code does not generate a Daily Roster Change and Language Codes do not appear on Daily 834 Changes. <u>Valid Language Codes (former AHCCCS Codes)</u>
					ALB	Albanian (A)
					AMH	Amharic (C)
					ARA	Arabic (D)
					ARM	Armenian (F)
					CAI	Central American Indian (5)
					CHI	Chinese, includes Cantonese & Mandarin (G and H)
					CRP	Creoles & Pidgins (other), includes Haitian (P)
					ENG	English (E)
					FRE	French (L)
					GER	German (M)
					GRE	Greek (N)
					HIN	Hindi (Q)
					HMN	Hmong (R)

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
					HUN ITA JPN KHM KOR LAO MIS MKH NAV NAI PER PHI POL POR RUS SAI SCC SCR SGN SOM SPA TGL UND VIE YID	Hungarian (V) Italian (X) Japanese (Y) Khmer (Z) Korean (1) Lao (2) Miscellaneous Languages, includes Indian (India) (W) Mon-Khmer (Other) (4) Navajo (6) North American Indian (Other), includes Hopi (T & 5) Persian, includes Farsi (J) Philippine (Other) (K) Polish (7) Portuguese (8) Russian (9) South American Indian (Other) (5) Serbian (0) Croatian (I) Sign Languages, includes ASL (B) Somali (@) Spanish (S) Tagalog (#) Undetermined, includes Other (O & U) Vietnamese (%) Yiddish (&)
2100B	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	70	The 2100B Loop is used when the member's name or demographic data (Date of Birth and Gender) are being changed.
2100B	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100B	NM1	NM103	Prior Incorrect Insured Last Name	The last name previously reported or used for an individual when a corrected name is reported		Prior Incorrect Last Name. Incorrect information that is being changed. Present when NM101 in Loop 2100A is 74.

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100B	NM1	NM104	Prior Incorrect Insured First Name	The first name previously reported or used for an individual when a corrected name is reported		Prior Incorrect First Name. Incorrect information that is being changed. Present when NM101 in Loop 2100A is 74.
2100B	NM1	NM105	Prior Incorrect Insured Middle Name	The middle name previously reported or used for an individual when a corrected name is reported		Prior Incorrect Middle Name. Incorrect information that is being changed. Present when NM101 in Loop 2100A is 74.
2100B	DMG	DMG01	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in format CCYYMMDD. Used when Member Date of Birth is incorrect.
2100B	DMG	DMG02	Prior Incorrect Insured Birth Date	The birth date previously reported or used for an individual when corrected data is reported		Prior Incorrect Date of Birth
2100B	DMG	DMG03	Prior Incorrect Insured Gender Code	The gender previously reported or used for an individual when corrected data is reported		Prior Incorrect Gender
2100C	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	31	Member's Postal Mailing Address
2100C	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100C	N3	N301	Subscriber Address Line	Address line of the current mailing address of the insured individual or subscriber to the coverage		First line of member's mailing street address
2100C	N3	N302	Subscriber Address Line	Address line of the current mailing address of the insured individual or subscriber to the coverage		Second line of member's mailing street address, if present
2100C	N4	N401	Subscriber City Name	The City Name of the insured individual or subscriber to the coverage		Member's mailing city
2100C	N4	N402	Subscriber State Code	The State Postal Code of the insured individual or subscriber to the coverage		Member's mailing state

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100C	N4	N403	Subscriber Postal Zone or ZIP Code	The ZIP Code of the insured individual or subscriber to the coverage		Member's mailing zip code (9 digit when available).
2300	HD	HD01	Maintenance Type Code	Code identifying a specific type of item maintenance	 001 021 024 030	<u>Used on Daily 834s</u> Change – Change in an existing coverage for a health plan member Addition – Addition of a new coverage for a new or existing health plan member Termination – Ending of a coverage for an existing or terminating health plan member <u>Used on Monthly 834s</u> Audit/Compare. No equivalent AHCCCS Code Use one of these values to describe the type of update in the 2300 Health Coverage Loop only. The entire loop is repeated for each type of coverage indicated by an Insurance Line Code (HD03).

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	HD	HD03	Insurance Line Code	Code identifying a group of insurance products		This is the element that determines the kind of 2300 Loop that follows. HMO Health Maintenance Organization – Used to identify medical health plans AK Mental Health – Used to identify Behavior Health Services (BHS) FAC Facility – Used to show nursing home residency or receipt of home based personal care. LTC Long Term Care – Used to identify Share of Cost information (up to six monthly segments, each with its own 2300 Loop) EPO Exclusive Provider Organization (Used by AHCCCS to show CRS eligibility) HLT Health (Used by AHCCCS to show Targeted Support Coordination [TSC – i.e., ALTECS non-DD] eligibility) AJ Medicare Risk – (Used by AHCCCS to show a Medicare Health Plan) AG Preventative Care/Wellness (Used by AHCCCS to show member pregnancy) The HMO 2300 Loop is always present on Monthly 834s and is present on Daily 834s when new health plan enrollments are added or enrollment data is changed. The other 2300 Loops appear on Monthly 834s for all current enrollments (except for the LTC Share of Cost Loops which occur up to six times on Monthly 834s for the six most recent Share of Cost months).

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	HD	HD04	Plan Coverage Description	A description or number that identifies the plan or coverage		Population of this element differs for each Insurance Line Code (HD03): HD03 = HMO – Rate Code (X[4]) in all situations. After Rate Code, AHCCCS strings Prior Plan ID (X[6]) and Prior Plan Name (X[25]) for Daily 834 re-enrollments (when INS03 in the 2000B Loop = "025"). When the PMMIS Action Code on a Daily 834 is "AA" (Algorithm Assigned) or "EC" (Enrollment Choice), the Rate Code, Prior Plan ID and Name appears with the Action Code (X[2]) at the end of the string. All fields in the string have a fixed length. Fields prior to the final field are replaced by spaces if not present. HD03 = AK – Mental Health Category (X[1]) HD03 = FAC – AHCCCS strings the LTC Transition Indicator (X[1], "T" or "N"), AHCCCS Provider ID (X[6]) for the nursing home or personal care giver, and the Provider Name (X[25]) in HD04. All fields in the string have a fixed length. Fields prior to the final field are replaced by spaces if not present. HD03 = LTC – Not used HD03 = EPO – The member's CRS ID (X[14]). HD03 = HLT – The member's TSC ID (X[10]). HD03 = AJ – The Medicare HMO ID (X[5]) and the Medicare HMO Name (X[40]). HD03 = AG – "PG" if the member is pregnant (X[2])

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	348 349 303	Benefit Begin Use when a member is enrolled in the coverage specified in the Insurance Line Code Benefit End Use when a member is terminated from the coverage specified in the insurance line code Maintenance Effective The exact meanings of these dates vary for different Insurance Line Code (HD03) values. On FAC 2300 Loops, the Maintenance Effective Date is the data that information was extracted from PMMIS. On LTC (Share of Cost) Loops, the Benefit Begin Date represents the first day of the Share of Cost month on up to six monthly segments. Otherwise, dates show periods of health plan enrollment or program eligibility.
2300	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in format CCYYMMDD Used when DTP01 above is populated.
2300	DTP	DTP03	Coverage Period	The coverage period associated with this premium payment		Population of this element differs for each Insurance Line Code (HD03): HMO – Enrollment Begin and/or End Date (both Begin and End Dates may be present for retroactive “block in/block out” enrollments and disenrollments) AK – Same as above for BHS enrollments. FAC – Date on which data was extracted from PMMIS. LTC – Begin Date of each Share of Cost month (up to six occurrences on separate 2300 Loops on Monthly 834s) EPO - The “Process Date” on which the program coverage was added to PMMIS HLT - Same as above. AJ – Same as above. AG – Same as above
2300	AMT	AMT01	Amount Qualifier Code	Code to qualify amount	C1	Co-payment Amount This AMT Segment is used only on “LTC” Share of Cost Loops. It appears for each SOC month.

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	AMT	AMT02	Contract Amount	Fixed monetary amount pertaining to the contract		The monthly Share of Cost Amount on “LTC” Loops.
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	IL	Group or Policy Number
2300	REF	REF02	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered		Contract Type Appears only in “HMO” 2300 Loops.
2320	COB	COB01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	U	On Monthly 834s, there can be up to five 2320 COB Loops for the member’s coverages by other payers during the enrollment period covered by the Begin and/or End Dates in Loop 2300, Element DTP03. The 2320 Loop is included only within the initial 2300 Loop. On Daily 834s, the 2320 Loop is included when another coverage is added, changed, or terminated. For “block in/block out” enrollments and disenrollments, TPL coverages are those in effect during the block in/block our period even if they are not in effect on the 834 creation date. On Monthly 834s, included TPL coverages are those currently in effect. Unknown
2320	COB	COB02	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered		Other Insurance Policy Number
2320	COB	COB03	Coordination of Benefits Code	Code identifying whether there is a coordination of benefits	5	Unknown
2320	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	6P	Group Number

834 ENROLLMENT TRANSACTION SPECIFICATIONS						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	REF	REF02	Insured Group or Policy Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered		The Group-Number of the other carrier's policy.
2320	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	IN	Insurer
2320	N1	N102	Insurer Name	Name of the insurer providing coverage		Insurer Name
2320	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	344 and/or 345	Begin Date for Other Insurance Coverage End Date for Other Insurance Coverage Two DTP Segments can occur when Begin and End Dates overlap health plan enrollment dates on retroactive adjustments.
2320	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in format CCYYMMDD. Used when DTP01 above is populated.
2320	DTP	DTP03	Coordination of Benefits Date	The dates of eligibility for coordination of benefits		The Begin or End Date of Other Insurance Coverage.
N/A	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		Count of all segments between the ST and SE Segments, including the ST and SE Segments. Format is numeric from 1 to 10 digits.
N/A	SE	SE02	Transaction Set Control Number	The unique identification number within a transaction set		This number is the same number that is in data element ST02.

5.3 820 Capitation Transaction Specifications

Overview

The purpose of these Transaction Specifications is to identify the data elements used in the 820 Capitation Payment Transaction so that health plans and other entities that receive 820 Transactions from AHCCCS will be able to understand and process transaction data. The 820 Transaction does not include or accompany capitation payments. Rather, it serves as a detailed capitation remittance advice that shows payments and adjustments for each member. The 820 Transaction represents the financial aspect of the pre-HIPAA Daily and Monthly Roster Files with capabilities added for mass adjustments and payments and withholds that are not member specific.

The AHCCCS Financial System implements Agency policy by making capitation payments to health plans and other entities paid on a per member or per recipient basis. To be consistent with AHCCCS payment policies, the Agency issues 820 Transactions on a weekly basis. Each 820 Transaction references categories of payments defined by AHCCCS. Capitated pre-payments generated at the same time as monthly 834s, for example, are paid and reported separately from daily capitation adjustments. AHCCCS pays accumulated daily payments and adjustments on a weekly basis.

The following entities receive 820 Transactions from AHCCCS:

- Acute and long term care health plans
- Arizona Behavioral Health Services (BHS)
- Arizona Children's Rehabilitative Services (CRS)

Only acute and long term care health plans are covered in this Companion Document.

Transaction Agreements Table

820 Capitation Transaction Agreements for individual data elements are shown in the table beginning on the next page. Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
The valid values from the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	820	Transaction Set Number A unique Transaction Number assigned by AHCCCS.
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set		The value of this element must be the same as that of the SE02 element at the end of the transaction.
N/A	BPR	BPR01	Transaction Handling Code	This code designates whether and how the money and remittance information will be processed	I	Remittance Information Only
N/A	BPR	BPR02	Total Premium Payment Amount	The total premium payment for this batch or transaction		The total payment amount on the 820 Transaction. This amount is the sum of the amounts in the RMR04 Detail Premium Payment Amount elements in the 2000A and/or 2000B Loops. It must also equal the amount of the health plan payment.
N/A	BPR	BPR03	Credit or Debit Flag Code	Code indicating whether amount is a credit or debit	C	Credit Negative dollar amounts are made with the Credit Flag by assigning a negative value to BPR02.
N/A	BPR	BPR04	Payment Method Code	Code identifying the method for the movement of payment instructions	ACH CHK FWT	Automated Clearing House Check Wire Transfer AHCCCS makes payments in all three ways, primarily by automated clearinghouse (ACH). Most elements in this segment are required for the “ACH” and “FWT” options.
N/A	BPR	BPR05	Payment Format Code	Type of format chosen to send payment	CCP CTX	Concentration/Addenda plus Disbursement Corporate Trade Exchange Used only with “ACH” of “FWT” networks.
N/A	BPR	BPR06	Depository Financial Institution (DFI) Identification Number Qualifier	Code identifying the type of identification number of Depository Financial Institution (DFI)	01	ABA (9-digit Transit Routing Number including check digits) originating the transaction when BPR04 is “ACH” or “FWT”.
N/A	BPR	BPR07	Originating Depository Financial Institution (DFI) Identifier	Number identifying the financial institution originating the transaction in an ACH network		ABA number of the financial institution originating the transaction when BPR04 is “ACH” or “FWT”.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	BPR	BPR08	Account Number Qualifier	Code indicating the type of account	DA	When BPR04 is “ACH” or “FWT”.
N/A	BPR	BPR09	Sender Bank Account Number	The sender's bank account number at the Originating Depository Financial Institution		Bank Account Number of the financial institution originating the transaction when BPR04 is “ACH” or “FWT”.
N/A	BPR	BPR10	Originating Company Identifier	A unique identifier designating the company originating the transaction	1866004791	The Federal Tax ID Number preceded by the number “1”. For the organization originating the transaction.
N/A	BPR	BPR12	Depository Financial Institution (DFI) Identification Number Qualifier	Code identifying the type of identification number of Depository Financial Institution (DFI)	01	ABA (9-digit Transit Routing Number including check digits) of the financial institution receiving the transaction when BPR04 is “ACH” of “FWT”.
N/A	BPR	BPR13	Receiving Depository Financial Institution (DFI) Identifier	Number identifying the financial institution receiving the transaction from an ACH network		ABA number of the financial institution receiving the transaction when BPR04 is “ACH” or “FWT”.
N/A	BPR	BPR14	Account Number Qualifier	Code indicating the type of account	DA	When BPR04 is “ACH” or “FWT”.
N/A	BPR	BPR15	Receiver Bank Account Number	The receiver's bank account number at the Receiving Depository Financial Institution		Bank Account Number of the financial institution receiving the transaction when BPR04 is “ACH” or “FWT”.
N/A	BPR	BPR16	Check Issue or EFT Effective Date	Date the check was issued or the electronic funds transfer (EFT) effective date		Date that the check was issued or that AHCCCS intends the transaction to be settled
N/A	TRN	TRN01	Trace Type Code	Code identifying the type of reassociation which needs to be performed	3	Financial Reassociation Trace Number. The payment and remittance information have been separated and need to be reassociated by the receiver.
N/A	TRN	TRN02	Check or EFT Trace Number	Check number or Electronic Funds Transfer (EFT) number that is unique within the sender/receiver relationship		Check Number or Trace Number (for electronic funds transfers)
N/A	TRN	TRN03	Originating Company Identifier	A unique identifier designating the company originating the transaction	1866004791	The AHCCCS Federal Tax ID Number preceded by the number “1”. For the organization originating the transaction.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	14	Master Account Number
N/A	REF	REF02	Premium Receiver Reference Identifier	The key or reference number used by the premium receiver to designate to which plan, invoice, or account number the premium payment is to be applied		The six-digit AHCCCS Health Plan ID
N/A	DTM	DTM01	Date Time Qualifier	Code specifying the type of date or time or both date and time	582	Report period
N/A	DTM	DTM05	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	Range of dates expressed in format CCYYMMDDCCYYMMDD.
N/A	DTM	DTM06	Coverage Period	The coverage period associated with this premium payment		Payment From and Payment Thru Date This date range covers all payments and adjustments in Loops 2000A and 2000B from the earliest detail level Payment Begin Date to the most recent detail level Payment End Date.
1000A	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PE	Payee
1000A	N1	N102	Information Receiver Last or Organization Name	The name of the organization or last name of the individual that expects to receive information or is receiving information		Health Plan Name
1000A	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	The health plan’s Federal Taxpayer's ID Number
1000A	N1	N104	Receiver Identifier	Number identifying the organization receiving the payment		Health Plan Tax ID Number
1000A	N3	N301	Receiver Address Line	The receiver's address line		Health Plan or Agency Street Address Line 1 Used when this element appears on a check (BPR04 = CHK).

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000A	N3	N302	Receiver Address Line	The receiver's address line		Health Plan or Agency Street Address Line 2 Used when this element appears on a check (BPR04 = CHK).
1000A	N4	N401	Information Receiver City Name	The City Name of the Information Receiver's address		Health Plan or Agency City Used when this element appears on a check (BPR04 = CHK).
1000A	N4	N402	Information Receiver State Code	The State Postal Code of the Information Receiver's address		Health Plan or Agency State Used when this element appears on a check (BPR04 = CHK).
1000A	N4	N403	Information Receiver Postal Zone or ZIP Code	The Zip Code of the Information Receiver's address		Health Plan or Agency Zip Code Used when this element appears on a check (BPR04 = CHK).
1000B	N1	N101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer
1000B	N1	N102	Premium Payer Name	Name identifying the organization remitting the payment	AHCCCS	Name of organization making the payment.
1000B	N1	N103	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer ID Number
1000B	N1	N104	Premium Payer Identifier	Number identifying the organization remitting the payment	866004791	AHCCCS' Federal Tax ID Number
1000B	N3	N301	Premium Payer Address Line	Address line for the premium payer's address		AHCCCS Street Address Line 1 Used when this element appears on a check (BPR04 = CHK).
1000B	N4	N401	Premium Payer City Name	The city name of the premium payer's address		AHCCCS City Used when this element appears on a check (BPR04 = CHK).
1000B	N4	N402	Premium Payer State Code	State postal code of the premium payer's address		AHCCCS State Code Used when this element appears on a check (BPR04 = CHK).
1000B	N4	N403	Premium Payer Postal Zone or ZIP Code	The postal zone code of the premium payer's address		AHCCCS Zip Code Used when this element appears on a check (BPR04 = CHK).

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000A	ENT	ENT01	Assigned Number	Number assigned for differentiation within a transaction set.		AHCCCS uses the 2000A Organization Summary Remittance Loop and the loops within it to show payment or withhold amounts that are not member specific. Settlement amounts, sanctions, and partial payments are examples of how AHCCCS can use the 2000A Loop. ENT01 is a unique number for each payment line within an 820 Transaction. AHCCCS begins numeration with a "1" for the initial payment line of the 2000A Loop if a 2000A Loop is present. Sequential numeration continues through any additional 2000A lines and into 2000B lines if any are present.
2000A	ENT	ENT02	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	2L	Corporation/Organization Required if the 2000A Loop is present.
2000A	ENT	ENT03	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer ID Number Required if the 2000A Loop is present.
2000A	ENT	ENT04	Organization Identification Code	The code identifying the organization providing the summary level premium remittance	866004791	AHCCCS Federal Taxpayer ID Number Used for sanctions, negotiated settlements and the BHS 820 Transaction. Required if the 2000A Loop is present.
2300A	RMR	RMR01	Reference Identification Qualifier	Code qualifying the reference identification	IK	Invoice Number Required if the 2000A Loop is present.
2300A	RMR	RMR02	Contract, Invoice, Account, Group, or Policy Number	The reference number to which this premium payment is associated, such as an account number, contract number, invoice number, group number, or policy number		The number of the invoice or voucher used to make the payment On 820 Transactions for medical health plans, the Invoice Number links payment lines to invoices generated by the AHCCCS Financial System.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300A	RMR	RMR04	Detail Premium Payment Amount	Detailed remittance amount on the transaction		The amount of the payment (positive) or recovery (negative) On partial payment RMR Segments for which the partial payment is for detail payments that appear in other 2000A and/or 2000B Loops, RMR04 is a negative amount that represents the amount not covered by the partial payment. The ADX Segment is not needed. When the partial payment is for a payment amount within a particular 2000A Loop, the element is the full payment amount and a positive value in ADX01 is the difference between the full payment amount and the partial, actual payment.
2310A	IT1	IT101	Line Item Control Number	Identifier assigned by the submitter/provider to this line item	1	The 2310A and 2315A Loops are required for “HIPAA health premium payments”, according to the Implementation Guide.
2315A	SLN	SLN01	Line Item Control Number	Identifier assigned by the submitter/provider to this line item		Within each claim, a sequential Line Numbers beginning with 1.
2315A	SLN	SLN03	Information Only Indicator	An indicator that this segment is informational only	O	Information
2315A	SLN	SLN04	Head Count	Number of members/insured under this summary line item remittance	0	AHCCCS fills this required element with zero.
2315A	SLN	SLN05-1	Unit for Measurement	Code specifying the units of which a value is being expressed, or manner in which a measurement has been taken	IE	Person
2320A	ADX	ADX01	Adjustment Amount	If negative, [the Adjustment Amount] reduces the provider payment; if positive, it increases the provider payment		In partial-payment-within-a-2000A-Loop situations, this is a negative amount representing the amount withheld from the provider’s payment.

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320A	ADX	ADX02	Adjustment Reason Code	Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	H6	Partial Payment AHCCCS makes use of the adjustment capability within the 2000A Loop to show partial payment of a Payment Amount within a particular 2000A Loop. For AHCCCS, this is the only situation in which the ADX Segment appears on an 820 Transaction.
2000B	ENT	ENT01	Assigned Number	Number assigned for differentiation within a transaction set		The 2000B Loop is used for member-level capitation payments and adjustments. EDT01 carries the line number of a member's payment or adjustment. If a 2000A Loop is present, starting with the next sequential number after the last number in the 2000A Loop's ENT01. If there is no 2000A Loop, numeration starts with "1" in this element.
2000B	ENT	ENT02	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	2J	Individual
2000B	ENT	ENT03	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	ZZ	Mutually Defined AHCCCS intends to use the HIPAA individual identifier when this identifier is adopted.
2000B	ENT	ENT04	Receiver's Individual Identifier	The identification number of the individual used by the receiver		Member's AHCCCS ID
2100B	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	QE	Policy Holder
2100B	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100B	NM1	NM103	Individual Last Name	The last name of an individual to which specific remittance amount(s) apply		Member's Last Name
2100B	NM1	NM104	Individual First Name	The first name of an individual to whom specific remittance amounts apply		Member's First Name
2100B	NM1	NM105	Individual Middle Name	Middle name of an individual to whom specific remittance amounts apply		Member's Middle Initial

820 CAPITATION TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300B	RMR	RMR01	Reference Identification Qualifier	Code qualifying the reference identification	AZ	Health Insurance Policy Number
2300B	RMR	RMR02	Insurance Remittance Reference Number	The reference number for this individual premium remittance, such as a policy number, account number, invoice number		A string of AHCCCS data within the 30-character field consisting of the following elements: • Contract Type X(1) • County X(2) • Rate Code X(4) • Voucher Number X(9) Within RMR02, these elements appear in a fixed format. Should an element ever not be present, the element's RMR02 sub-field is filled with spaces.
2300B	RMR	RMR04	Detail Premium Payment Amount	Detailed remittance amount on the transaction		Capitation Amount This element is used for both original capitation payments and capitation adjustments. AHCCCS does not explicitly distinguish between original payments and adjustments in its pre-HIPAA Rosters or in the 820 Transaction.
2300B	DTM	DTM01	Date Time Qualifier	Code specifying the type of date or time or both date and time	582	Report period
2300B	DTM	DTM05	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	RD8	Range of dates expressed in format CCYYMMDDCCYYMMDD.
2300B	DTM	DTM06	Coverage Period	The coverage period associated with this premium payment		Capitation Coverage Period for the member
N/A	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		A count of all segments between the ST and SE Segments, including the ST and SE Segments. Format is numeric from 1 to 10 digits.
N/A		SE02	Transaction Set Control Number	The unique identification number within a transaction set		This number is the same number that is in data element ST02 at the beginning of the transaction.

Appendix A – AHCCCS Action Code Translation Table

Action Type	Action Code	Description	834 Translation/Maintenance Reason Code Value
A	$P	Manual Payment	820 Transaction – no map for 834.
A	AA	Algorithm Assigned	No translation- Mapped to HD04 in the 2300 Loop.
A	AE	Applied for New Eligibility	28 – Initial Enrollment
A	AI	Admin-In	28 – Initial Enrollment
A	BI	Enrollment Block In	28 – Initial Enrollment
A	CI	County Move-In	28 – Initial Enrollment
A	EC	Enrollment Choice	Mapped to HD04 in the 2300 Loop 28 – Initial Enrollment
A	EI	Open Enrollment-In	The health plan will receive a Potential Transition Listing separately. 28 – Initial Enrollment
A	FI	Family Continuity-In	28 – Initial Enrollment
A	MI	Medical Care Continuity-In	28 – Initial Enrollment
A	MR	Mass Adjustment Recoupment	820 Transaction – no map for 834
A	NB	Newborn	02 - Birth
A	NE	Normal Enrollment	28 - Initial Enrollment
A	NP	Normal Enrollment Prior Plan	28 – Initial Enrollment
A	PA	End of Contract-In - Auto Ass	28 – Initial Enrollment
A	PD	End of Contract- In - Direct	28 – Initial Enrollment
A	PP	End of Contract- In - Percent	28 – Initial Enrollment
A	PR	End of Contract - In - Rule M	28 – Initial Enrollment
A	RA	Retroactive Enrollment	28 – Initial Enrollment
A	RE	Re-Enrollment	41 - Re-enrollment
C	AC	Address Change	43 - Change of location
C	C1	"Combination Action Code" DB, NC, SX	25 - Change in Identifying Data Element
C	C2	"Combination Action Code" DB, NC	25 - Change in Identifying Data Element
C	C3	"Combination Action Code" DB, SX	25 - Change in Identifying Data Element
C	C4	"Combination Action Code" NC, SX	25 - Change in Identifying Data Element
C	CP	Co-pay Change	33 - Personnel Data
C	DB	Date of Birth Change	25 - Change in Identifying Data Element
C	HC	Acute Health Plan Change	22 – Plan Change
C	HK	Hospital Kick	820 Transaction – no map for 834
C	IC	SSN Change	Not Used
C	MC	Mental Health Change	A separate 2300 loop with HD03 = "AK" 22 – Plan Change
C	NC	Name Change	25 - Change in Identifying Data Element
C	OC	Other Change	Not Used
C	PG	Pregnant Women	Create a separate 2300 loop with HD03 = "AG". AI – No Reason Given

Action Type	Action Code	Description	834 Translation/Maintenance Reason Code Value
C	RC	Rate Code Change	29 - Benefit Selection
C	SB	Supplemental Birth Payment	820 Transaction – no map for 834
C	SC	Share of Cost Change	33 - Personnel Data
C	SX	Sex Change	25 - Change in Identifying Data Element
C	TM	Mental Health Termination	No translation - Create a separate 2300 loop with HD03 = "AK"
D	$R	Manual Recoupment	820 Transaction – no map for 834
D	AO	Admin Out	22 - Plan Change
D	BO	Enrollment Block Out	Maintenance Reason Code will be blank Plans do not receive now
D	CH	Eligibility Change - Disenroll	07 – Termination of Benefits
D	CO	County Move-Out	22 – Plan Change
D	DE	Deceased	03 - Death
D	EO	Open Enrollment-Out	The Health Plan will still receive Potential Transition Listing separately. 07 – Termination of Benefits
D	FO	Family Continuity-Out	07 – Termination of Benefits
D	HO	Move out of Health Plan Area	07 – Termination of Benefits
D	IE	Ineligible	07 - Termination of Benefits
D	MA	Mass Adjustment Recoup	820 Transaction – no map for 834
D	MO	Medical Care Continuity-Out	07 – Termination of Benefits
D	OS	Out of State Move	07 – Termination of Benefits
D	PO	End of Contract - Out - Direct	07 – Termination of Benefits
D	PT	End of Contract-Out - %, AA,	07 – Termination of Benefits
D	RO	Recoupment MHS	820 Transaction – no map for 834
D	VW	Voluntary Withdrawal	14 - Voluntary Withdrawal
C	NONE	FYI Changes	AI – No Reason Given
C	NONE	TPL Changes	AI – No Reason Given